

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 012798	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/20/2014
NAME OF PROVIDER OR SUPPLIER CROWNPOINTE OF GREENFIELD		STREET ADDRESS, CITY, STATE, ZIP CODE 831 SWOPE STREET GREENFIELD, IN 46140		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00159534.</p> <p>Complaint IN00159534 -- Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey date: November 18, 19 and 20, 2014</p> <p>Facility number: 012798 Provider number: 012798 AIM number: N/A</p> <p>Survey team: Penny Marlatt, RN</p> <p>Census bed type: Residential: 44 Total: 44</p> <p>Census Payor type: Medicaid: 14 Other: 30 Total: 44</p> <p>Sample: 4</p> <p>Crownpointe of Greenfield was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00159534.</p> <p>Quality Review 11/21/14 by Lisa McColly</p>	R 000		

Indiana State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE